

**THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

3317

State File No. _____

No. 300
10-48

FILED FEB 14 1949

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BIRTH NO. 49-54356 REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u>		d. STREET ADDRESS (If rural, give location) <u>4207 Papin</u>	

3. NAME OF DECEASED (Type or Print) <u>Zachary Surette</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>1 3 49</u>			
a. (First) _____		b. (Middle) _____		c. (Last) _____		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____		
8. DATE OF BIRTH <u>12-28-48</u>			9. AGE (In years last birthday) _____		IF UNDER 1 YEAR _____ Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? _____						

13a. FATHER'S NAME <u>Alonzo Surette</u>		13b. MOTHER'S MAIDEN NAME <u>Edith Jones</u>		14. NAME OF HUSBAND OR WIFE _____	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Katherine M. Shepard, R.N.</u> ADDRESS <u>2601 N. Whittier</u>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Premature Birth Neonatal Death</u>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						_____	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Intracranial Hemorrhage</u>						_____	

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____				
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR? _____				
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22. I hereby certify that I attended the deceased from 12-28-, 1948, to 1-3-, 1949, that I last saw the deceased alive on 1-3-, 1949, and that death occurred at 3:20a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W. D. Phillips, M.D.</u>			23b. ADDRESS <u>2601 N. Whittier St.</u>			23c. DATE SIGNED <u>1-6-49</u>		
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24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>JAN 31 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>			24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
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DATE REC'D BY LOCAL REG. <u>JAN 31 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Labater</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland Mortuary Service</u> ADDRESS: <u>1104 Manchester Ave.</u>				
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(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

..... Student Embalmer No.

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.